STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	09/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING HOUSE OF MARION	2452 W KEM RD MARION, IN46952

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R0000	This visit was for a State Residential Licensure Survey. Survey dates: September 27, 28, 2011 Facility number: 010682 Provider number: 010682 Aim number: N/A Survey team: Betty Retherford RN, TC Karen Lewis RN Delinda Easterly RN Census bed type: Residential: 42 Total:42 Census payor type: Other: 42 Total: 42 Sample: 8 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed 9/28/11 Cathy Emswiller RN	R0000	The following is the Plan of Correction for Sterling House of Marion in regards to the Statement of Deficiencies for the annual survey completed on 9/28/2011. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy that objective.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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R0241	(e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on record review and interview, the facility failed to ensure sliding scale insulin was administered correctly in accordance with physician's orders for 2 of 2 residents reviewed with orders for sliding scale insulin in a sample of 8. (Resident #13 and #22) Findings include: 1.) The clinical record for Resident #13 was reviewed on 9/27/11 at 1:30 p.m. Diagnoses for Resident #13 included, but were not limited to, Dementia, Diabetes Mellitus, type 2, and anxiety. Admission physician's orders, dated 5/8/11, indicated Resident #13 was to have blood sugar checks done four times daily. The orders indicated sliding scale Novolog insulin was to be given based on the blood sugar results. The amounts of insulin to be given included, but were not limited to, the following: Blood sugar results 181-200- give 2 units	R0241	**R 241:** ***What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?*** · Resident # 13: This resident suffered no adverse effects due to the alleged deficient practice. The licensed nurse involved in the alleged medication discrepancy is no longer employed at this community. Going forward, this resident now has a new flow sheet placed in the Medication Administration Record where the sliding scale insulin orders and accu-check readings may be documented on the same page for easier reference. A new Flow sheet will be introduced at the nurses meeting scheduled on Oct. 21, 2011 this flow sheet will have the current sliding scale orders with a place to document the blood sugar. · Resident # 22: This resident suffered no adverse effects due to the alleged deficient practice. Going forward, this resident now has a new flow sheet placed in the Medication Administration Record where the sliding scale insulin orders and accu-check readings may be documented on the same page for	10/22/2011

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	Blood sugar results 221-260- give 3 units... The June 2011 Medication Administration Record (MAR) indicated sliding scale insulin had been given based on blood sugar readings which were below 181 as noted below: 6/4/11 at dinner-blood sugar 177- 2 units of insulin was documented as having been given 6/4/11 at bedtime-blood sugar 157- 2 units of insulin was documented as having been given 6/6/11 at bedtime-blood sugar 180- 2 units of insulin was documented as having been given 6/8/11 at dinner-blood sugar 157- 2 units of insulin was documented as having been given 6/9/11 at dinner-blood sugar 178- 2 units of insulin was documented as having been given The clinical record lacked any order for insulin to be given for the blood sugar levels noted above. The July 2011 MAR indicated insulin given was not in accordance with physician's orders on the following date and time:		easier reference. A new Flow sheet will be introduced at the nurses meeting scheduled on Oct. 21, 2011 this flow sheet will have the current sliding scale orders with a place to document the blood sugar. ***How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken?*** · Other diabetic residents with orders for sliding scale insulin have the potential to be affected by the alleged deficient practice. For this reason the clinical records for all diabetic residents with sliding scale insulin orders have been reviewed by the Health and Wellness Director and compared to the documentation on the MARs for accuracy and completeness. No other residents were noted to be affected by the alleged deficient practice. **What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur?** · A meeting was held on September 30 th , 2011 between the Executive Director, Health and Wellness Director, the consulting pharmacist and the director of the community's preferred pharmacy. · As a result of the meeting, the pharmacy has agreed to present an inservice at the community during the month of October (for nurses)	

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	7/2/11 at bedtime-blood sugar 231-no insulin was documented as having been given. Three units of insulin should have been given.		related to "Insulin Administration and Diabetes". · In addition, every 60 days, the pharmacy consultant will check the re-writes versus all new orders since the last visit for accuracy. The pharmacy has also agreed to have medical records perform a "double check" of the Medication Administration Record before sending to the community each month. · The pharmacy will further print all diabetic orders (Insulin, Accu-checks, glucagon, etc.) on a separate MAR form for easier tracking. · The community will now have a separate documentation binder which will be used to separate all diabetic orders from other orders in the MAR for ease of reference and to enable double checks to be performed daily by the Health and Wellness Director, Executive Director/Designee. · **How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put in place?** · Medical records will have a double check system in place at the pharmacy whereby all orders are reviewed by two separate parties before sending to the community each month. · The Health and Wellness	

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	2.) Clinical record was reviewed for Resident #22 on 9/27/11 at 10 a.m. Diagnoses for Resident #22 included, but were not limited to, diabetes mellitus, hypertension, dementia, and hypothyroidism. The current July 2011 recapitulation of physician orders indicated Resident #22 was to have his blood sugar monitored 4 times daily at 8 a.m., 12 p.m., 5 p.m., and 9 p.m. The orders indicated Novolog sliding scale insulin was to be given based on the blood sugar ranges noted below: 150-200 = 3 UN (units) 201-250 = 5 UN		Director and the Executive Director will be monitoring the diabetic MAR binder daily for accuracy. · Every 60 days, the pharmacy consultant will be checking all insulin orders for each resident receiving insulin on each visit to verify orders. · All diabetic residents will be discussed twice monthly during the collaborative care meeting process to review any potential discrepancies and address them immediately. ***By what date will these systemic changes be implemented?*** ***10/22/11*** -	

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	251- 300 = UN 301-399 = 9 UN If greater than 400 call provider The orders indicated the original order date was 7/22/11. The above insulin sliding scale order lacked the amount of insulin to be given for the blood sugar range of 251-300. The June 2011 Medication Administration Record (MAR) had a handwritten "8" in front of the units for the blood sugar range of 251-300. The clinical record lacked any telephone order clarifying the amount of insulin to be given for the range of 251-300. On the following dates, 8 units of insulin was given: 6/18/11 dinner 287 6/18/11 bedtime 286 6/19/11 bedtime 272 6/25/11 bedtime 263 6/28/11 lunch 251 The July 2011 MAR for the blood sugar range of 251-300 had nothing in front of the units for the blood sugar range of 251-300. On the following dates, 7 units of insulin was given: 7/4/11 bedtime 258			

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	7/8/11 bedtime 253 7/19/11 dinner 294 3.) During an interview with the Administrator and Director of Nursing on 9/27/11 at 3:45 p.m., additional information was requested related to the insulin coverage concerns noted above for Resident #'s 13 and 22. During an interview on 9/28/11 at 8:30 a.m., the Director of Nursing indicated she had reviewed the orders and medication administration records for Resident #13 and #22 and had no information to provide related to the insulin given on those dates. 4.) Review of a current facility policy, dated June 2003, provided by the Administrator on 9/28/22 at 10:15 a.m., titled "Insulin Injection/Glucometer Readings", included, but was not limited to, the following: "Background Insulin is a hormone that controls the level of blood sugar, also called glucose, in the body. People with diabetes either do not produce enough insulin or have a dysfunction in their cells that make them unable to use the insulin properly.... ...Insulin Injection Techniques... ...Injection...			

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	...Check MAR: Right drug, Right resident, Right dose...".			
R0349	(a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on record review an interview, the facility failed to ensure clinical records were complete and accurate in regards to insulin orders for 2 of 2 residents reviewed with orders for sliding scale insulin in a sample of 8 . (Resident #13 and #22) Findings include: 1.) The clinical record for Resident #13 was reviewed on 9/27/11 at 1:30 p.m. Diagnoses for Resident #13 included, but were not limited to, Dementia, Diabetes Mellitus, type 2, and anxiety. Admission physician's orders, dated 5/8/11, indicated Resident #13 was to have blood sugar checks done four times daily. The orders indicated sliding scale Novolog insulin was to be given based on	R0349	**R 349:** ***What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?*** · Resident # 13: This resident suffered no adverse effects due to the alleged deficient practice. The licensed nurse involved in the alleged medication discrepancy is no longer employed at this community. Going forward, this resident now has a new flow sheet placed in the Medication Administration Record where the sliding scale insulin orders and accu-check readings may be documented on the same page for easier reference. A new Flow sheet will be introduced at the nurses meeting scheduled on Oct. 21, 2011 this flow sheet will have the current sliding scale orders with a place to document the blood sugar. · Resident # 22: This resident suffered no adverse effects due to the	10/22/2011

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	the blood sugar results. The amounts of insulin to be given included, but were not limited to, the following: Blood sugar results 181-200- give 2 units The August 2011 recapitulation of physician's orders, dated 8/9/11, indicated 2 units of sliding scale insulin was to be given for blood sugar results ranging from 190-220. The clinical record lacked any written or telephone order changing the blood sugar range from 181-220 to 190-220. During an interview with the Director of Nursing on 9/28/11 at 8:30 a.m., she indicated she was unable to provide any information related to the change in the blood sugar range order noted above for Resident #13. 2.) The clinical record for Resident #22 was reviewed on 9/27/11 at 10 a.m. Diagnoses for Resident #22 included, but were not limited to, diabetes mellitus, hypertension, dementia, and hypothyroidism. The current July 2011 recapitulation of physician orders indicated Resident #22 was to have his blood sugar monitored 4		alleged deficient practice. Going forward, this resident now has a new flow sheet placed in the Medication Administration Record where the sliding scale insulin orders and accu-check readings may be documented on the same page for easier reference. A new Flow sheet will be introduced at the nurses meeting scheduled on Oct. 21, 2011 this flow sheet will have the current sliding scale orders with a place to document the blood sugar. ***How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken?*** · Other diabetic residents with orders for sliding scale insulin have the potential to be affected by the alleged deficient practice. For this reason the clinical records for all diabetic residents with sliding scale insulin orders have been reviewed by the Health and Wellness Director and compared to the documentation on the MARs for accuracy and completeness. No other residents were noted to be affected by the alleged deficient practice. **What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur?** · A meeting was held on September 30 th , 2011 between the Executive Director, Health and	

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	times daily. The orders indicated Novolog sliding scale insulin was to be given based on blood sugar readings as noted below: 150-200 = 3 UN (units) 201-250 = 5 UN 251- 300 = UN 301-399 = 9 UN... The orders indicated the original order date was 7/22/10. The above insulin sliding scale order lacked the amount of insulin to be given for the blood sugar range of 251-300. The June 2011 Medication Administration Record (MAR) had a handwritten "8" in front of the units for the blood sugar range of 251-300. The clinical record lacked any telephone order clarifying the amount of insulin to be given for the range of 251-300. The July 2011 MAR for the blood sugar range of 251-300 had nothing in front of the units for the blood sugar range of 251-300. During an interview with the Director of Nursing on 9/28/11 at 8:30 a.m., she indicated she was unable to provide any information related to the insulin orders and medication record documentation		Wellness Director, the consulting pharmacist and the director of the community's preferred pharmacy. · As a result of the meeting, the pharmacy has agreed to present an inservice at the community during the month of October (for nurses) related to "Insulin Administration and Diabetes". · In addition, every 60 days, the pharmacy consultant will check the re-writes versus all new orders since the last visit for accuracy. The pharmacy has also agreed to have medical records perform a "double check" of the Medication Administration Record before sending to the community each month. · The pharmacy will further print all diabetic orders (Insulin, Accu-checks, glucagon, etc.) on a separate MAR form for easier tracking. · The community will now have a separate documentation binder which will be used to separate all diabetic orders from other orders in the MAR for ease of reference and to enable double checks to be performed daily by the Health and Wellness Director, Executive Director/Designee. · **How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put in place?**	

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	noted above for Resident #22.		· Medical records will have a double check system in place at the pharmacy whereby all orders are reviewed by two separate parties before sending to the community each month. · The Health and Wellness Director and the Executive Director will be monitoring the diabetic MAR binder daily for accuracy. · Every 60 days, the pharmacy consultant will be checking all insulin orders for each resident receiving insulin on each visit to verify orders. · All diabetic residents will be discussed twice monthly during the collaborative care meeting process to review any potential discrepancies and address them immediately. ***By what date will these systemic changes be implemented?*** · ***10/22/11***	